

under section 104 to be completed before the termination or reduction takes effect.

(i) **RULE OF CONSTRUCTION.**—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) **RETROSPECTIVE DETERMINATION.**—A group health plan, and a health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a denial of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) **CONDUCT OF REVIEW.**—

(1) **IN GENERAL.**—A review of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(2) **PEER REVIEW OF MEDICAL DECISIONS BY HEALTH CARE PROFESSIONALS.**—A review of an appeal of a denial of a claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts—

(A) shall be made by a physician (allopathic or osteopathic); or

(B) in a claim for benefits provided by a non-physician health professional, shall be made by reviewer (or reviewers) including at least one practicing non-physician health professional of the same or similar specialty; with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) and acting within the appropriate scope of practice within the State in which the service is provided or rendered, who was not involved in the initial determination.

(d) **NOTICE OF DETERMINATION.**—

(1) **IN GENERAL.**—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such subparagraph).

(2) **FINAL DETERMINATION.**—The decision by a plan or issuer under this section shall be treated as the final determination of the plan or issuer on a denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this section within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external review under section 104.

(3) **REQUIREMENTS OF NOTICE.**—With respect to a determination made under this section, the notice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the determination; and

(C) notification of the right to an independent external review under section 104

and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) **RIGHT TO EXTERNAL APPEAL.**—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

(b) **INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.**—

(1) **TIME TO FILE.**—A request for an independent external review under this section shall be filed with the plan or issuer not later than 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 103(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(2) **FILING OF REQUEST.**—

(A) **IN GENERAL.**—Subject to the succeeding provisions of this subsection, a group health plan, or health insurance issuer offering health insurance coverage, may—

(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

(ii) limit the filing of such a request to the participant, beneficiary, or enrollee involved (or an authorized representative);

(iii) except if waived by the plan or issuer under section 103(a)(4), condition access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 103;

(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed \$25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) **REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.**—

(i) **ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.**—In the case of an expedited or concurrent external review as provided for under subsection (e), the request for such review may be made orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such a review without regard to whether and when a written confirmation of such request is made.

(ii) **EXCEPTION TO FILING FEE REQUIREMENT.**—

(I) **INDIGENCY.**—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the appropriate Secretary) that

the participant, beneficiary, or enrollee is indigent (as defined in such guidelines).

(II) **FEE NOT REQUIRED.**—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 103(a)(4).

(III) **REFUNDING OF FEE.**—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse or modify the denial which is the subject of the review.

(IV) **COLLECTION OF FILING FEE.**—The failure to pay such a filing fee shall not prevent the consideration of a request for review but, subject to the preceding provisions of this clause, shall constitute a legal liability to pay.

(c) **REFERRAL TO QUALIFIED EXTERNAL REVIEW ENTITY UPON REQUEST.**—

(1) **IN GENERAL.**—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 103(d)(3)(A)), to a qualified external review entity selected in accordance with this section.

(2) **ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.**—With respect to an independent external review conducted under this section, the participant, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

(3) **SCREENING OF REQUESTS BY QUALIFIED EXTERNAL REVIEW ENTITIES.**—

(A) **IN GENERAL.**—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

(i) any of the conditions described in clauses (ii) or (iii) of subsection (b)(2)(A) have not been met;

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) the denial of the claim for benefits is a decision as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2).

Upon making a determination that any of clauses (i) through (iv) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (C).

(B) **PROCESS FOR MAKING DETERMINATIONS.**—